PLEASE PRINT AND COMPLETE ALL INFORMATION BELOW AND BRING TO EXAMINATION APPOINTMENT

REGISTRATION FORM DATE _____

Patient Name _____
First M. Initial Last Name you like to be called

Birthdate _____/_____/_____ Age_____ ☐ Male ☐ Female ☐ Unmarried ☐ Married

Mailing Address _____ Cell Phone (_____)_____

City, State, Zip _____ Home Phone (_____) _____

Soc. Sec. # _____ E-mail _____

Employer _____ Occupation _____

Work Phone (_____) _____ Is it O.K. to call you at work? ☐ Yes ☐ No

Spouse's Name _____ Occupation _____

Employer _____ Work Phone (_____) _____

Whom may we thank for referring you? _____

In case of emergency, a local relative or friend to be notified (not living at same address).

Name _____ Relationship to Patient _____

Address _____ Phone (_____) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co. _____ Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

Mailing Address _____ Insurance Co. Phone # (_____) _____

City, State, Zip _____ Insurance Group # _____

Subscriber's Name _____ Union Local # _____

Subscriber's ID# _____ Birthdate _____/_____/_____

Secondary Insurance Co. _____ Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

Mailing Address _____ Insurance Co. Phone # (_____) _____

City, State, Zip _____ Insurance Group # _____

Subscriber's Name _____ Union Local # _____

Subscriber's ID# _____ Birthdate _____/_____/_____

I give my consent for Dr. Sebastian and his staff to release any of my dental records to my insurance companies, physician, general dentist or any other doctor related to my care. I authorize release of any information to my medical and/or dental insurance companies relating to services with Dr. Sebastian. I authorize insurance payments to be directly made to Mark J. Sebastian DMD.

Both the above and the medical history on the reverse side are accurate. _____ Date _____/_____/_____
Signature (if patient is a minor, then parent or guardian)

TURN OVER ➟

Your present dentist _____ City _____ How long? _____

Last tooth cleaning _____

Have you ever had previous periodontal (gum treatment)? ☐ Yes ☐ No

When and by whom _____

Is there anything you want us to know regarding your dental treatment? ☐ Yes ☐ No

Describe _____

Name of physician _____ City _____ Phone _____

Check if you are allergic or have reacted adversely to any of the following?

☐ Dental anesthetics (Novacaine, etc.)	☐ Codeine	☐ Ibuprofen	☐ Sulfa drugs
☐ Penicillin/Amoxcilin	☐ Percodan / Percocet	☐ Aspirin	☐ Sulfite preservatives
☐ Barbiturates, sedatives, or sleeping pills	☐ Demerol	☐ Tylenol	☐ Latex
	☐ Vicodin	☐ Tetracycline	☐ Clindamycin
☐ Valium, Halcion, or other Benzodiazapenes	☐ Keflex/Cipro	☐ Erythromycin	☐ Iodine
☐ Other _____			☐ Sutures/stitches

Have you ever used intravenous (injected) bisphosphonates (Zometa, Aredia, Boniva, or Reclast)?_____

Have you ever had chemo therapy?_____

Are you now using or ever used oral (pill) bisphosphonates (Fosamax, Actonel, Atelvia, or Boniva)? _____

Have you ever been told you may need any antibiotic premedication for dental appointments?_____

Are you on any special diet? _____

Do you currently smoke? Y / N Amount _____ Smokeless tobacco / snuff? Y / N

Have you ever had extensive radiation therapy? _____

List all medications you are now taking (Rx, over the counter, or natural/herb supplements)_____

_____

Do you have or have you ever had any of the following diseases or problems?

PLEASE CHECK IF YES:

☐ Rheumatic fever	☐ Sleep disorder	☐ Sleep Apnea	☐ Cancer
☐ Rheumatic heart disease	☐ Seizures or epilepsy	☐ Kidney disease	
☐ Pacemaker	☐ Alcoholism	☐ Liver disease	
☐ Heart murmur	☐ Drug addiction	☐ Hepatitis A / B / C	
☐ Heart trouble	☐ Diabetes	☐ AIDS / HIV positive	
☐ High blood pressure	☐ Stomach ulcers	☐ Asthma	
☐ Artificial heart valves	☐ Arthritis	☐ Tuberculosis	
☐ Artificial joints	☐ Glaucoma	☐ Respiratory (Lung) disease	
☐ Prostate disorders	☐ Hemophilia	☐ Thyroid or parathyroid disorders	
☐ Anemia	☐ Bleeding disorders	☐ Osteoporosis/Osteopenia	
	☐ Depression/Bi-Polar/Schizophrenia	☐ Anxiety	

Please describe any other information you feel we should be aware of relative to your health: _____

_____

WOMEN:

Are you pregnant? ☐ Yes ☐ No If yes, expected delivery date _____

Do you think you might be pregnant?	☐ Yes	☐ No
Are you breast feeding?	☐ Yes	☐ No
Are you taking female hormones (oral contraceptives, etc.)?	☐ Yes	☐ No

PLEASE INFORM THE DOCTOR IF YOUR HEALTH CHANGES IN ANY WAY